HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Kansas Medical Assistance Programs

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Amevive (Alefacept®) Prior Authorization Request Form

Consumer Name: _____

Consumer Medicaid ID #: _____ Date Of Birth: _____/_____/_____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Drug Name: _____ NDC Requested: _____

- OR -

Prescribing Physicians Name: _____Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

J-Code requesting: _____ # of units requesting: _____

1. Please indicate the diagnosis for which Amevive is being prescribed (no dx codes):

_____

2. Documentation of inadequate response to one or more conventional therapies:

_____
_____
_____
_____
_____
_____

3. Documentation of appropriate lab testing:

Total Lymphocyte: _____Date: _____
CD4: _____ Date: _____
T Cell Count: _____ Date: _____

_____
_____
_____

Prescribing Physician's Signature: _____ Date: ___/___/_____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within 15 working days, the case will be denied.

Revised 3/2006